New Jersey Department of Health and Senior Services

REQUEST FOR HUMAN WEST NILE VIRUS TESTING PATIENT INTAKE RECORD

*Fields in **BOLD** are required information. Reports will not be processed if these fields are not completed.*

PLEASE CLEARLY PRINT ALL INFORMATION!

Date Form Being Submitted: ____ / ____ / ____

Date of First Symptoms (REQUIRED) ____ / ____ / ____

FOR NJDHSS USE ONLY

NJ ID: _____

Date Report Rec'd: ____/____/____

Received By: _____

Record Entry Date: ____/____/____

Approved for WNV Testing? ☐ Yes ☐ No

1. IDENTIFYING PATIENT INFORMATION

Last Name

First Name | MI

Date of Birth ____ / ____ / ____ | Age (years) Years | Sex ☐Male ☐Female

Street Address | Apt. No.

City | State | Zip Code | County

Home Telephone No. | Work Telephone No.

2. REPORTED BY

Last Name | First Name

Title (ICP, Resident, Attending, etc.) | Specialty (if applicable)

Work Address | City | State | Zip Code

Telephone No. | Pager No. | Fax No.

3. PHYSICIAN TREATING PATIENT

Last Name | First Name

Title (ICP, Resident, Attending, etc.) | Specialty (if applicable)

Work Address | City | State | Zip Code

Telephone No. | Pager No. | Fax No.

Send Report to (check all that apply):

☐Physician Above ☐Other Physician: _____

_____

PATIENT INTAKE RECORD (Continued)

4. CLINICAL INFORMATION

Admitting Diagnosis:

☐ Encephalitis ☐ Meningitis ☐ Guillian-Barre Syndrome ☐ Fever Syndrome

☐ Other (specify): _____

Was Patient Hospitalized?

☐ Yes ☐ No

Hospital Name	City	State

Medical Record Number	**Admission Date**	**Discharge Date**
	____ / ____ / ____	____ / ____ / ____

Fever:	☐ Yes	☐ No	☐ Unknown	Stiff Neck:	☐ Yes	☐ No	☐ Unknown
Headache:	☐ Yes	☐ No	☐ Unknown	Photophobia:	☐ Yes	☐ No	☐ Unknown
Altered Mental Status:	☐ Yes	☐ No	☐ Unknown	Seizure:	☐ Yes	☐ No	☐ Unknown
Muscle Weakness:	☐ Yes	☐ No	☐ Unknown	Rash:	☐ Yes	☐ No	☐ Unknown
Other Neurologic Signs:	☐ Yes (specify): _____					☐ No	☐ Unknown
Other Symptoms:	☐ Yes (specify): _____					☐ No	☐ Unknown
Antiviral Treatment:	☐ Yes (specify): _____					☐ No	☐ Unknown
Antibiotic Treatment::	☐ Yes (specify): _____					☐ No	☐ Unknown

PATIENT OUTCOME:

☐ Recovered ☐ Still in Hospital ☐ Still Ill, Discharged Home ☐ Unknown

☐ Died - Date of Death: ____ / ____ / ____

5. LABORATORY AND DIAGNOSTIC TESTING RESULTS

Lumbar puncture performed? ☐ Yes (Date Performed): ____ / ____ / ____ ☐ No ☐ Pending/Planned

CSF Results: Glucose _____ Protein _____ RBC _____ WBC _____ % Lymph _____ % Segs _____

Differential _____ %Polys _____ Gram Stain _____ Bacterial Culture _____

Parasite or Fungal Culture _____ Viral culture _____

If performed:

CBC Date: ____ / ____ / ____ WBC _____ %Lymph _____ %Segs _____

MRI Date: ____ / ____ / ____ Result: _____

EMG Date: ____ / ____ / ____ Result: _____

CT Date: ____ / ____ / ____ Result: _____

Vaccination History

Yellow fever vaccine? ☐ Yes ☐ No List date(s) given:

Other Pertinent Information (brief history, clinical findings or relevant lab data):

Please fax completed form to (609) 588-2546,
Attention: WNV Human Surveillance, Communicable Disease Service, NJDHSS.

Once a report is received at the NJDHSS, staff will contact you on whether this patient is approved for West Nile Virus testing. If approved for testing, we will provide additional information on shipping specimens. If you have any questions, please call (609) 588-3121.